California Institute for Mental Health

Connecting Patient Record Information between Physical and Behavioral Health Care Organizations

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www.integration.samhsa.gov
Flavors of Health Information Exchange
Secure Messaging Exchange
Uses DIRECT Protocols
Meets Meaningful Use Requirements

Easy
Exchange Among Providers in One system

Somewhat Difficult but Occurring Nationally

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Exchange Among Providers in Multiple Systems

More Difficult but Occurring Nationally
ONC’s Goal - Information Securely Follows Patients Whenever and Wherever They Seek Care

QUERY-BASED EXCHANGE

- Find patient information to support unplanned care

DIRECTED

- Send and receive patient information to support care coordination

CONSUMER-MEDIATED EXCHANGE

- Patients aggregate use and share their own information
ONC’s Approach

Interoperability is a journey, not a destination

Leverage government as a platform for innovation to create conditions of interoperability

Health information exchange is not one-size-fits-all

Multiple approaches will exist side-by-side

Build in incremental steps – “don’t let the perfect be the enemy of the good”
ONC’s Role - Reduce Cost and Increase Trust and Value To Mobilize Exchange

**COST**
- **Standards**: identify and urge adoption of scalable, highly adoptable standards that solve core interoperability issues for full portfolio of exchange options
- **Market**: Encourage business practices and policies that allow information to follow patients to support patient care
- **HIE Program**: Jump start needed services and policies

**VALUE**
- Payment reforms
- Meaningful Use
- Interoperability and wide-scale adoption

**TRUST**
- Identify and urge adoption of policies needed for trusted information exchange

ONC’s ROLE
Exchange Priorities in 2012 - Driving Forward on Multiple Fronts

- More rigorous exchange requirements in Stage 2 to support better care coordination
- Standards building blocks are in place, with clear priorities to address missing pieces in 2012
- NwHIN Governance increases trust and reduces the need for one-to-one negotiations among exchange organizations
- State HIE Program jump starts needed services and policies
More Rigorous Exchange Requirements in Stage Two to Support Better Care Coordination
Proposed Stage Two Meaningful Use Exchange Requirements (summary)

- Provide summary of care document for more than 65% of transitions of care and referrals with **10% sent electronically** (across vendor and provider boundaries)
- Patients can **view, download or transmit** their own health information
- **Successful ongoing submission** of information to public health agencies (immunizations, syndromic surveillance, ELR)
Standards Building Blocks are in Place, with Clear Priorities to Address Missing Pieces
ONC Made Big Strides to Enable Exchange in Stage 1

The first challenge was to make sure that information produced by every EHR was understandable by another clinician and could be incorporated into his EHR.

With the vocabularies, code sets and content structure standards in Stage 1 meaningful use every certified EHR can produce the standardized content needed:

- Produce and consume a standardized care summary
- Maintain standardized medication lists
- Consistently report quality measures and public health results
- Consume structured lab results
Next we needed a common approach to transport, allowing information to move from one point to another.

- We now have two easily adopted standards for transporting information – NwHIN Direct and the transport protocol used in NwHIN Exchange.

And it was clear that we needed more highly specified standards to support care transitions and lab results delivery.

- For the first time in our country’s history there is a single, broadly-supported electronic data standard for patient care transitions.
This Year We Will Address the Missing Components to Support Scalable Exchange

- **Directories** – standards and policies to make them consistent, reliable, findable and open to be queried

- **Certificate management and discovery** - common guidelines for establishing and managing digital certificates and making the public keys “findable”

- **Governance** - baseline set of standards and policies that will accelerate exchange by assuring trust and reducing the cost and burden of negotiations among exchange participants
Using Data to Improve Care

Center for Integrated Health Solutions (CIHS)

- The SAMHSA-HRSA CIHS is funded under a training and technical assistance cooperative agreement with SAMHSA

- Update on CIHS HIT Supplement
  - Individual Grantees
  - 5 state HIE Initiative

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Change in Section H Indicators from Baseline to Most Recent Recording - Oct 11, 2012

- Blood Pressure - Systolic
- Blood Pressure - Diastolic
- Blood Pressure - Combined
- BMI
- Waist Circumference
- Plasma Glucose (fasting)
- Breath CO
- GHB1c
- Total Cholesterol
- HDL Cholesterol
- LDL Cholesterol
- Triglycerides

Legend:
- At-risk at Baseline
- Outcome Improved
- No Longer At-risk
HIE Supplement

Goals

- To develop infrastructure supporting the exchange of health information among behavioral health and physical health providers
- Development or adaptation of electronic health information exchange (HIE) systems to support the exchange
- Work through the challenges of exchanging 42 CFR data and implement a process to do so
- Identify the behavioral health data elements that should be part of the CCD
Eligibility Criteria:

- There must be a PBHCI Grantee in the state
  - 29 States

- Behavioral Health must be specifically included in their State Plan on the ONC web site
  - A Behavioral Health Organization or person identified as a Behavioral Health representative is clearly included
    - On the Steering Committee
    - On the Advisory Committee
    - Or there was a specific Behavioral Health Workgroup

- 12 States met criteria
- 8 submitted applications
### Applications Sent Out

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One non solicited application received from Alabama. There are no PBHCI Grantees in Alabama
States Awarded HIE Supplement Sub Awards

- IL
- KY
- ME
- OK
- RI
Who Participated:

- State HIE Director
- State HIT Director/Coordinator
- State Mental Health Authority
- State Substance Abuse Authority
- State Medicaid Director
- Others as identified by the state
HIE Supplement
Coordination with Other Federal Programs & Initiatives

- Coordinated Activities with
  - HL7 Behavioral Health CCD Workgroup
  - ONC’s Standards and Interoperability Framework Transitions of Care Workgroup
  - ONC’s Standards and Interoperability Framework Data Segmentation Workgroup
  - ONC’s State Health Policy Consortium Project (RTI Initiative) for behavioral health data sharing
    - AL, FL, KY, NE, NM, MI Plus other states

- Other states are also participating: CO; NY; UT, LA
Data Integrity
Follow the Continuity of Care Document / C-CDA
Psychotherapy Notes are not Sent

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**S&I Companion Guide** references (links) on CEHRT Vocabularies:

- **CDT** – Dental Codes
- **CPT** – AMA Procedure Codes
- **HCPCS** – Procedure Codes
- **CVX** – HL7 table 0292
- **RxNorm** – Medication Codes
- **ICD** – 10 CM / PCS
- **ISO 639-2** Language Codes
- **LOINC** – Lab Codes
- **OMBB Race / Ethnicity Codes**
- **SNOMED CT** – via UMLS

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[Source: www.integration.samhsa.gov]
C-CDA Header Constraints

It describes constraints that apply to the header for all documents within the scope of this implementation guide.

- Header constraints specific to each document type are described in the appropriate document-specific section below.

SHALL contain:

- realmCode
- typeld
- templateld
- id
- code
- title
- effectiveTime
- confidentialityCode
- languageCode

- recordTarget
  - w/ 1 patient
    - name in US realm format
    - administrativeGenderCode
    - birthtime (precise to the year)
    - ethnicity
    - preferred Language
    - race

- author
- custodian
- encompassing Encounter
  - healthcareFacility
  - responsibleParty
  - encounterParticipant

- serviceEvent
  - effectiveTime
  - performer
    - addr
    - name
Behavioral Health Specific Data Elements

- DSM Axis 1
- DSM Axis 2
- DSM Axis 3
- DSM Axis 4
- DSM Axis 5
- Environmental Factors (Housing Status)
- Functional Assessment Score
- Homicidal Risk
- Suicidal Risk
- Treatment Referral

What other elements do behavioral health providers need to do our job??
Provider Engagement

IL
- 5 Provider focus Groups
  - Illinois Mental Health Summit
  - Illinois Alcoholism & Drug Dependence Association
  - Illinois HIE Advisory Committee
  - Legislative & Budget Committee of the Social Service Advisory Council
  - Board of Directors of the Illinois Association of Rehabilitation Facilities;
- Also coordinated Conferences with
  - Community Behavioral Healthcare Association;
  - Illinois Association of Rehabilitation Facilities;
  - Illinois Association for Community Health Centers

KY
- Howard L. Bost Memorial Policy Forum (statewide) focused on integration of behavioral health and the HIE
- Implemented on-site visits prior to onboarding to HIE
- Medical providers requested the use of the consent form statewide
- Reviewed at the Kentucky Health Information Management Association Meeting
- Outreach coordinators now engage medical providers about behavioral health during their on-boarding process discussions

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Provider Engagement

ME
- One Provider focus Group
- 6 Behavioral Health Strategic Action Taskforce Statewide Meetings

OK
- Behavioral Health workgroup Chair hosts regular meetings with providers. Approximately 38% of all providers have attended at least one of these meetings/calls
- Two Statewide Provider Meetings

RI
- Two statewide Provider Meetings
Consumer Engagement

IL
- Held four (4) Consumer Focus Groups
  - Coordinated with the Illinois Department of Human Services
  - Community Behavioral Health Care Association
  - Illinois association of Rehabilitation Facilities
  - Illinois Alcoholism and Drug Dependence Association

KY – incorporated feedback from:
- Office of Protection & Advocacy within the Cabinet for Health &Family Services – Consumer Representatives
- The Protection & Advocacy Advisory Council for Individuals with Mental Illness (PAMI)
- Voices for Healthy Kentucky
- Consumers recommended that no guardianship be accepted on the form without proof of a guardianship order
Consumer Engagement

ME
- Held five (5) Consumer Focus Groups
  - Guardians of persons with intellectual disabilities; Seniors (65+); Veterans; Adults (25-65) and Youth (24 and younger)

OK
- Ongoing communication by Behavioral Health workgroup Chair with the state Mental Health Planning and Advisory Council

RI
- Ongoing input from the State HIE Consumer Advisory Committee
Spin Offs to Other Programs

KY
- All Behavioral health providers using consent form
- State Hospitals and Cabinet for Health & Family Services contracted providers will also use the form

ME
- Applied for CMMI State Healthcare Innovation Plan Testing Grant which includes behavioral health
- Applied for grant with State of Maine to support BH HIE/EHR – if awarded will result in hiring
CIHS T/TA to Other HIEs

- **eBHIN** (Electronic Behavioral Health Network of Nebraska)
- **PCE Systems** (Michigan Behavioral Health Network – just announced they will share behavioral health information in MI)
- **CORHIO** (Colorado Regional Health Information Organization)
- **OH- HIE**
- **Western NY HIE**
- **Louisiana Public Health Institute**
- **North Carolina HIE**
Outcomes

IL
- Implemented Direct Secure Messaging for Behavioral Health providers
  - Over 70 have Direct addresses
  - 6 behavioral health organizations in pilot projects
  - Legislative changes recommended to assist in information sharing for mental health information
    - HB1017 & SB 1186 – both introduced in January 2013

KY
- 4 behavioral health organizations in pilot projects
- Behavioral Health providers receive lab work data via the CCD from KHIE
  - Avoided the expense of a costly interface with the lab vendor
  - Behavioral Health providers are now included in future discussions of HIE functionality
- Still working on sharing Part 2 information from the behavioral health providers into the HIE (no data segmentation)
- Amending state legislation to allow for state run mental health facilities to participate
Outcomes

ME
- Behavioral health is now embedded in all discussions around PCMH and ACOs
- Provide access to the operational statewide bi-directional exchange: 5 agencies, total 70 users and growing
- View/Download: 20 agencies, 115 users and growing

OK
- New Policy and Procedures for behavioral health providers to use an opt-in model
- 27 organizations and 365 individual clinicians now have access to the state HIEs (34% penetration rate) 152 are via DIRECT Secure Messaging. At least one provider in all 77 counties in OK are covered

RI
- Will begin to share mental health & substance use information in March 2013 (Providence Center & Gateway)
- 9 CMHOs at 32 sites have enrolled for DIRECT and Currentcare Viewer Access
Artifacts

IL
- Development of a Consent Toolkit for Providers
- Completed a provider capacity study to evaluate readiness for HIE
- Developed a web-based Transitions of Care Tool with specific data elements needed for transitioning care. Vetted with providers

KY
- Development of CEU eligible web-based training on consent and sharing behavioral and physical health data – available to anyone nationally
- Development of a checklist for behavioral health providers with minimal requirements for their EHRs to participate
- Development of a KY specific Training Manual for providers
Artifacts

ME
- Printed consent form for patients to “opt-in” mental health information
- Language specific to mental health information and options for consent to insert into existing materials for patients and providers
- Modified all existing communications materials to accommodate patient and provider feedback.
  - This included a 4-page brochure, one page brochure, talking points, provider education materials and external materials such as website text, press releases and patient newsletters.

OK
- Developed statewide policy guideline for sharing behavioral health records

RI
- BHDDH’s Health Home Audit Requirements
- A special form which allows a CMHO to release information to CurrentCare
- New version of the CurrentCare Viewer which enables disclosure of information collected from Part 2 treatment programs.
C32, CCR/CCD, CDA
Clinical Element Data Dictionary
http://wiki.siframework.org/Transitions+of+Care+Initiative+CEDD

- HL7 Behavioral Health CCD Workgroup
- ONC’s Standards and Interoperability Framework
  - Transitions of Care Workgroup (ToC)
  - Data Segmentation Workgroup
  - Longitudinal Care Workgroup (LC Workgroup)
  - Clinical element Data Dictionary (CEDD)

- CEDD, ToC and LC Workgroup Data dictionaries still need to be harmonized
Data Elements Recommended by the 5 States & Their Workgroups

What is Needed to Provide Better Quality Care?

Personal Information
- Guardian
- Emergency contact
- Crisis plan

Encounters
- Psych admission

Family History
- Marriage status
- Children

Functional Status
- Housing status
- Risk status for suicide/homicide
- History of Risk of Violence
- History of Risk of Suicide

- Social History
  - Court orders
- Medications
  - Specialty of prescriber
  - History of psychiatric medications
  - Medication history
- Advance Directives
  - Behavioral Health Advance Directive
- Insurance Status
- Plan of Care
  - Treatment plan
- DSM Diagnosis (all 5 Axis)
What’s Missing?

Community Referral and Care Coordination Tool (CRCCT)
Care Transitions
Bopping Around the Spectrum of Care

Graph showing transitions between different levels of care, such as Home Care, Adult Care, Independent Care, Acute Care, SNE, ALF, PACE, IRF, LTAC, and Hospice, with axes for relative cost and acuity level.
Overview of HIE Activity Informing Consent Management Issues
Biggest Hurdle

42 CFR Part 2 Consent Management
“To Whom”

Predominant Challenge:

- Development of a 42 CFR Compliant Consent that is Computable in a HIE Environment
- Awareness of What is Possible Today
- Planning for What Will be Possible in the Future
- Recognize we are in a Transition Period
- Not all 42 CFR conditions can be fully met, however, patient still has complete control of consent
Our Approach:

- Build on What is Already Developed
- Coordinate with ONC & S&I Workgroups
- Coordinate with SAMHSA
- Ensure Legal Input
  - 3 of 5 HIEs have their legal experts regularly involved on the calls
- Identify current “Better Practices”
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- Identify current “Better Practices”
- 42 CFR Regs and SAMHSA FAQs 1 and 2 side by side as Consent developed
- HIEs obtained input from their Behavioral Health Workgroups
- HIEs invited their vendors to participate and comment as well
- Everything in “Black” was reviewed and found acceptable by everyone
- “Red” indicates problem areas not yet resolved (as of 6/29/12 still in process of determining a resolution)
A written consent to a disclosure under the Part 2 regulations must be in writing and include all of the following items (42 CFR § 2.31):

1) the specific name or general designation of the program or person permitted to make the disclosure;
2) the name or title of the individual or the name of the organization to which disclosure is to be made;
3) the name of the patient;
4) the purpose of the disclosure;
5) how much and what kind of information to be disclosed;
6) the signature of the patient and, when required for a patient who is a minor, the signature of a person authorized to give consent under § 2.14; or, when required for a patient who is incompetent or deceased, the signature of a person authorized to sign under § 2.15 in lieu of the patient;
7) the date on which the consent is signed;
8) a statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer; and
9) the date, event or condition upon which the consent will expire if not revoked before. This date, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.
PATIENT CONSENT AND AUTHORIZATION FORM FOR DISCLOSURE OF CERTAIN HEALTH INFORMATION

***PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW***

Patient (name and information of person whose health information is being disclosed):

Name (First Middle Last): ___________________________ Date of Birth (mm/dd/yyyy):____

Address: ___________________________ City: _______________ State: _____ Zip:_______

You may use this form to allow your healthcare provider to access and use your health information. Your choice on whether to sign this form will not affect your ability to get medical treatment, payment for medical treatment, or health insurance enrollment or eligibility for benefits.

By signing this form, I voluntarily authorize access, use and disclosure of my:

Check all of the boxes to identify the information you authorize to disclose:

☐ Drug or alcohol abuse treatment information
☐ Mental health treatment information
**FROM WHOM:** Specific name or general description of person(s) or organization(s) who I am authorizing to release my information under this form:

- All health care providers involved in my care.
- All programs in which the patient has been enrolled as an alcohol or drug abuse patient, or
- Any drug or alcohol treatment program or other health care provider, pharmacy or organization providing care coordination that is affiliated with the XYZ HIO

- Only these providers

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<tr>
<th>Person/Organization Name:</th>
<th>Phone:</th>
<th>Address:</th>
<th>Secure email address:</th>
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**TO WHOM:** Specific person(s) or organization(s) permitted to receive my information:

- To the HIE [Name]
- The HIE and any provider(s) involved in my care in the HIE as of today’s date ONLY
- The HIE and only these specific providers
- Only these specific providers
- The HIE and any current and future provider(s) involved in my care in the HIE

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<tr>
<th>Organization Name:</th>
<th>Phone:</th>
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<td>ONLY THESE INDIVIDUAL PROVIDERS</td>
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Most HIEs cannot manage only specific individual providers at this point in time
States Recommended that this wording in the “To whom” Section

☐ The HIE and any current and future provider(s) involved in my care in the HIE

Be interpreted as acceptable in the same way that:

“Provider of On Call Coverage” is acceptable as the “name or title of the individual or the name of the organization to which disclosure is to be made”


A Patient/Client/Consumer would know who a provider “involved in their care” is but would not really know who “Provider of On-Call coverage” is.
**Amount and Kind of Information:** The information to be released may include but not be limited to: Laboratory, Medications, Medical Care & HIV/AIDS, Alcohol & Substance Abuse and Mental or Behavioral Health information
PURPOSE: The information shared will be used:

☐ To help with my Treatment and Care Coordination

☐ To assist the provider or organization to improve the way they conduct work

☐ To help Pay for my Treatment

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<tr>
<th>Treatment</th>
<th>ONLY USE WHAT IS APPROPRIATE FOR THE HIE. SOME HIES ONLY PROVIDE EXCHANGE FOR “TREATMENT”</th>
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<tr>
<td>Operations</td>
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<td>Payment</td>
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**EFFECTIVE PERIOD:** This authorization/consent/permission form will remain in effect until (enter date, event or condition upon which this authorization/consent expires):

________________________________________________________

______

**OR**

This authorization/consent/permission form will remain in effect for (X Year(s) or X Month(s)) from the date the form is signed.

**OR**

This authorization/consent/permission will remain in effect until such time as XYZ HIO ceases to exist.

If there is no date entered the consent will be valid for one year from the date this form is signed.

Best practice is to always ask for a date any date. Events are not computable e.g. how to tell when someone dies. HIE would never know.
REVOKING MY PERMISSION: I can revoke my permission at any time by giving written notice to the person or organization named above in the “To Whom” or “From Whom” sections except to the extent the disclosure agreed to has been acted on.
In addition:

- I understand that an electronic copy of this form can be used to authorize the disclosure of the information described above.

- I understand that there are some circumstances in which this information may be redisclosed to other persons according to state or federal law.

- I understand that refusing to sign this form does not stop disclosure of my health information that is otherwise permitted by law without my specific authorization or permission.

- I have read all pages of this form and agree to the disclosures above from the types of sources listed.

“This HIE consent does not permit use of my protected health information in any criminal or civil investigation or proceeding against me without an express court order granting the disclosure unless otherwise permitted under state law.”
Signature of Patient or Patient’s Legal Representative
(mm/dd/yyyy)

___________________________________________

Date Signed

Print Name of Legal Representative (if applicable)

Check one to describe the relationship of Legal Representative to Patient (if applicable):

☐ Parent of minor
☐ Guardian
☐ Other personal representative (explain: ________________________________)

NOTE: Under some state laws, minors must consent to the release of certain information. The law of the state from which the information is to be released determines whether a minor must consent to the release of the information.
This form is invalid if modified. You are entitled to get a copy of this form after you sign it.
Issues/Challenges:

- Some HIEs cannot process only specific providers in the “To Whom” Section
  - Is “All or Nothing”

- Is “All or Nothing” for “Type and Amount” of Data
  - Data Segmentation is not available in all systems today to support Data Segmentation

- HIEs cannot currently process “Only providers in the HIE as of the date of signing the form”

- Barriers due to technology, cost & operational issues for HIEs and providers
Possible Solutions:

- Use DIRECT only with a Provider Locator Service provided and supported by the HIE
- Can work in an HIE that is not storing any data and just providing the “pipes” e.g. IL HIE
- Other solutions are in development
Possible Solutions:

- Bring behavioral health data into the HIE but do not “render” it to the provider until the provider has attested with a second sign on that they have a treating relationship with the patient.
- 4 of the 5 HIEs do require this attestation.
  - All have audit trail capabilities to track access.
- Other solutions are in development.
ONC S&I Data Segmentation Workgroup

- Each Data element will be tagged at the EHR level with data describing the actual data to be delivered
  - “Metadata”

- Metadata will include attributes of the data to be shared in relation to consent e.g.
  - Is “Restricted” or “Confidential” in nature
  - Effective Date of consent
  - Termination date of consent
  - If not “all providers” which specific providers are allowed access etc.
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Secure Messaging Exchange
Uses DIRECT Protocols
Meets Meaningful Use Requirements

- If HIE Consent wording is not found acceptable
- Using DIRECT Secure Messaging may be the only option available for exchanging Part 2 information
Contact:

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